DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2111

Registration District No. 129 — Primary Registration District No. 5180 — Registrar's No. 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Neelys Landing Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Neelys Landing Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn (b) County Davidson
(c) City or town Nashville
(If outside city or town limits, write "RURAL")
(d) Street No. 3814 Belleaire Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Bertha Bruce
3. (b) If veteran, name war _____
3. (c) Social Security No. None
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank J Bruce
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased Feb (Month) 15 (Day) 1871 (Year)
8. AGE: Years 69. Months 11 Days 15 If less than one day _____ hr. _____ min.
9. Birthplace New Wells Mo (City, town, or county) O (State or foreign country)
10. Usual occupation Housework
11. Industry or business _____
FATHER 12. Name Jacob Wunderlich
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mary Louise Gall
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Herbert Wunderlich Jr
(b) Address Neelys Landing Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 1941 (Month) (Day) (Year)
(c) Place: burial or cremation New Wells Mo.
18. (a) Signature of funeral director McCombs Funeral Co
(b) Address Jackson Mo
19. (a) Jan 20-41 (Date received local registrar) (b) F. J. Schoen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19 year 1941 hour 9 minute 30 P M.
21. I hereby certify that I attended the deceased from Jan 14, 1941, to Jan 19, 1941; that I last saw her alive on Jan 14, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Influenza	6 days
Due to _____	
Due to _____	
Other conditions Pneumonia (Include pregnancy within 3 months of death)	about 4 days

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W L Eisenmayer (M. D. or other)
Address Jackson Mo Date signed 1-20-41

(Licensed Embalmer's Statement on Reverse Side)

FEB 201948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed B A Meyer

Licensed Embalmer No. 3057

P. O. Address Jackson Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
1-21-40
X22659

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STANDARD CERTIFICATE OF DEATH

State File No. 2111

Registration District No. 129 Primary Registration District No. 5180 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Bertha Bruce

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Influenza	
Due to	
Due to	
Other conditions Paralysis agitans (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W. L. Matthews (M. D. or other)
Address Jackson Mo Date signed 4-16-41